

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5393

CERTIFICATE OF DEATH

Reg. Dist. No. 05385

1. PLACE OF DEATH o. COUNTY CAROLINE	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	b. COUNTY CAROLINE
In CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GREENSBORO	c. LENGTH OF STAY IN 1b 3 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON	d. STREET ADDRESS /
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION /	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

3. NAME OF DECEASED (Type or print)	First HARRIETT	Middle 	Last BULLOCK	4. DATE OF DEATH Month MAY	Day 23	Year 1961
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 9, 1871	9. AGE (In years, months, days, birthdate) yrs. 89	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME JACOB H. KIRK	14. MOTHER'S MAIDEN NAME ELMIRA
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Talmae Strong Denton	Address 101 W. Main Street, Denton, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		
4221	DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. {	(b) DUE TO	Generalized Arteriosclerosis
	(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
Fracture of pelvis		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fracture of pelvis			20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from May 5, 1961 , to May 23, 1961 , that I last saw the deceased alive on May 22, 1961 , and that death occurred at 2:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Stonesifer	M.D.	ADDRESS (Street, city or town, state) Greensboro, Md.					

PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	DATE SIGNED 5/25/61
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22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF May 26, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Penn Hill	22d. LOCATION (City, town, or county) Penn Hill Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Knue	ADDRESS /	24a. REC'D BY REGISTRAR DATE MAY 31 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Knue

81-3800373A8-2011ACM 80 7MBR73A-3D 35A2 0100 35A8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5394

Reg. Dist. No.

65386

1. PLACE OF DEATH a. COUNTY Caroline			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN lb yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Henry Edward Christ, Sr.			4. DATE OF DEATH May 23, 1961	Month	Day
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1892	9. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret. Navy			10b. KIND OF BUSINESS OR INDUSTRY service	11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Frederick Christ			14. MOTHER'S MAIDEN NAME Yohanna (unknown)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I, II		17. INFORMANT Mrs. Henry Christ, Denton, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heminal Hemorrhage from 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Descending Heart DUE TO (c) Relair to Glaria		Ammed. site 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

22b. DATE THEREOF
May 29, 1961

22c. NAME OF CEMETERY OR CREMATORIAL
Arlington Nat. Cem.

22d. LOCATION (City, town, or county)
(State)
Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS
J. George Moore Son Denton Md.

24a. REC'D BY REGISTRAR
DATE
MAY 31 '61

24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas

MECHANICAL EXAMINER'S CERTIFICATE OF DEATH

14

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No.

U5387

5395

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DENTON b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY MICHAEL DETWILER, SR.		First	Middle
		Last	4. DATE OF DEATH MAY 9 1961
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL DRIVER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME ABRAHAM DETWILER	
14. MOTHER'S MAIDEN NAME MARY CULP		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MR FRANCES T. DETWILER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X (b) Diabetes Mellitus DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 1959-1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HILLSBORO	20f. (City or town) (County) HILLSBORO (State) MD
21. I certify that I attended the deceased from Sep 25 1959 to May 9 1961 , that I last saw the deceased alive on May 9 1961 , and that death occurred at HILLSBORO MD , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dawson D George	PHYSICIAN'S NAME (Type) Dawson D George M.D.	ADDRESS (Street, city or town, state) Hillsboro, Maryland	
DATE SIGNED May 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 12	22c. NAME OF CEMETERY OR CREMATORIAL GREENMON	22d. LOCATION (City, town, or county) HILLSBORO
23. FUNERAL DIRECTOR'S SIGNATURE J Virgil Moore & Son		ADDRESS DENTON	24a. REC'D BY REGISTRAR DATE May 18 '61
			24b. REGISTRAR'S SIGNATURE Charles L. Kline

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film G288 6/6/61 iwk

Reg. Dist. No.

05388

1. PLACE OF DEATH a. COUNTY		CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		NEW JERSEY b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL PRESTON		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Greip Farm, Tanyard		d. STREET ADDRESS		67 X-3			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
M		AUGUST		DE YOUNG	MAY	30	1961		
S. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH	AUG. 16, 1905		9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	53 yrs.		Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						NEW JERSEY			
12. CITIZEN OF WHAT COUNTRY?						USA			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
JOHN DE YOUNG			MARTHA HASCUP						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			
NO						Address E41 ARMLE RD MRS. AUGUST DE YOUNG PARANUS NJ			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 mnts</u>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE		<u>Dawson D. George</u>							DATE SIGNED
EXAMINER'S NAME (Type)		<u>DAWSON D. George</u>							<u>5-30-61</u>
22a. BURIAL, CREMATION, REMOVAL(Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)			
Burial		JUNE 2, 1961		Geo Washington		Paramus, N.J. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<u>J. Vogel Inc.</u>				DATE JUN 1 '61		<u>Arthur J. Hause</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trousser permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEEDICIDE EXCAVATION OR **WEEDICATE** OR **WEEDICATE** OR **WEEDICATE**

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	c. LENGTH OF STAY IN lb X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS Preston	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Fred W. Edgell	First Middle Last 4. DATE OF DEATH Month Day Year May 23 1961	
5. SEX M W	6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH May 4, 1875	
9. AGE (In years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY US	
13. FATHER'S NAME Wesley Edgell	14. MOTHER'S MAIDEN NAME Julia Christopher Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> no	16. SOCIAL SECURITY NO. 213-22-7365	
17. INFORMANT Leona O. Edgell		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Generalized carcinomatosis Conditions, if any, which gave rise to immediate cause (b) DUE TO Carcinoma of bladder- (a), stating the underlying cause last. (c)	INTERVAL BETWEEN ONSET AND DEATH 3 mo 4 years?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterosclerotic heart disease - fracture rt. hip.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. (City or town) (County) (State) Preston, Md. Anne Arundel County Maryland
21. I certify that (I) (this hospital) attended the deceased from 9-11-41, 19..., to May 23, 1961, that (I) (we) last saw the deceased alive on 5-22-1961, and that death occurred at 5:15 P.M. from the causes and on the date stated above.		
22a. SIGNATURE Harold B. Plummer	M.D.	22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) Harold B. Plummer
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 26, 61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Choptank Preston, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Hall	23d. LOCATION (City, town or county) Choptank	25a. REC'D BY REGISTRAR DATE MAY 29 '61
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5398

Reg. Dist. No.

65390

1. PLACE OF DEATH a. COUNTY CAROLINE	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PRESTON	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PHILADELPHIA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS 75X-3
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First HELEN	Middle PAULINE	Last HOPKINS	4. DATE OF DEATH Month MAY	Day 27	Year 1961
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5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1905	9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY	10b. KIND OF BUSINESS OR INDUSTRY RET. MERCHANTING	11. BIRTHPLACE (State or foreign country) MARYLAND USA	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME WALLACE HOPKINS	14. MOTHER'S MAIDEN NAME DELLA CHEAVES
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address WALLACE HOPKINS, DENTON, MD
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH Immediate
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head On Collision - Auto.	
DUE TO (b) Fractured Skull	
DUE TO (c) Internal Injuries	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway - Route 16	
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20c. TIME OF INJURY Month, Day, Year Hour p.m. May 21 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Denton	(County) Baltimore County	(State) Maryland
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE Dawson George	DATE SIGNED May 30, 1961
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EXAMINER'S NAME (Type) Dawson George M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 30, 1961	22c. NAME OF CEMETERY OR CREMATORIAL DENTON	22d. LOCATION (City, town, or county) DENTON	(State) Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE Angus Johnson Denton, Md.	ADDRESS Angus Johnson Denton, Md.	24a. REC'D BY REGISTRAR DATE JUN 1 '61	24b. REGISTRAR'S SIGNATURE Charles S. Thomas
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MISSOURI STATE BOARD OF EXAMINERS
MEDICAL EXAMINERS' EXAMINATIONS

1920

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05391

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL PRESTON		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE		First HOPKINS	Middle HOPKINS
4. DATE OF DEATH MAY 27 1961		Last HOPKINS	Month MAY
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 14 1912
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY WALLACE HOPKINS	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALLACE HOPKINS		14. MOTHER'S MAIDEN NAME DELLA CLEAVES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. WALLACE HOPKINS	
17. INFORMANT DENTON, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head On W. Collision			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pushed Chest - Internal injuries			
DUE TO (b) Multile Fractures			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Highway - 16 - Route	
20c. TIME OF INJURY Month, Day, Year Hour 5-27 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural Preston - Caroline Md
		20f. (City or town) DENTON	(County) DENTON
		(State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson D. George		DATE SIGNED May 31-61	
EXAMINER'S NAME (Type) Dawson D. George M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF May 30, 1961	
22c. NAME OF CEMETERY OR CREMATORIAL DENTON		22d. LOCATION (City, town, or county) DENTON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Mooreton Denton		24a. REC'D BY REGISTRAR Arthur S. Kraus	
ADDRESS		DATE JUN 1 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Reg. Dist. No. 05392

5400

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb d. STREET ADDRESS	
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
		Harrison	Hubbard
4. DATE OF DEATH		Month	Doy
		May	21
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 8-1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Farmer		Ranching Farms	Caroline
12. CITIZEN OF WHAT COUNTRY?		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Harrison Hubbard		Mollie Hubbard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		212-12-0142	Address Edna Hubbard, Hurlock, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Automobile Accident Immediately	
818X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) Multiple Fractures and Internal Injuries	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Head On Collision	
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural Res.
3:30 p.m. 5-21 1961		Not while of work	Rural Res., Caroline, Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		DATE SIGNED May 29, 1961	
ACTUAL SIGNATURE <i>Dawson O. George</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery	
22d. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) Hurlock, Md.	
22b. DATE THEREOF 6/3/1961		24a. REC'D BY REGISTRAR DATE JUN 2 '61	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert W. Schlegel Jr., Cambridge, Md.</i>		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

СЕМЕЙСТВО ПОДДЕРЖАЛО СТАВРОПОЛЬСКИЙ КОМБИНАТ
ПОДДЕРЖАЛ СТАВРОПОЛЬСКИЙ КОМБИНАТ

СТАВРОПОЛЬСКИЙ КОМБИНАТ

M

11 09/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, copy the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

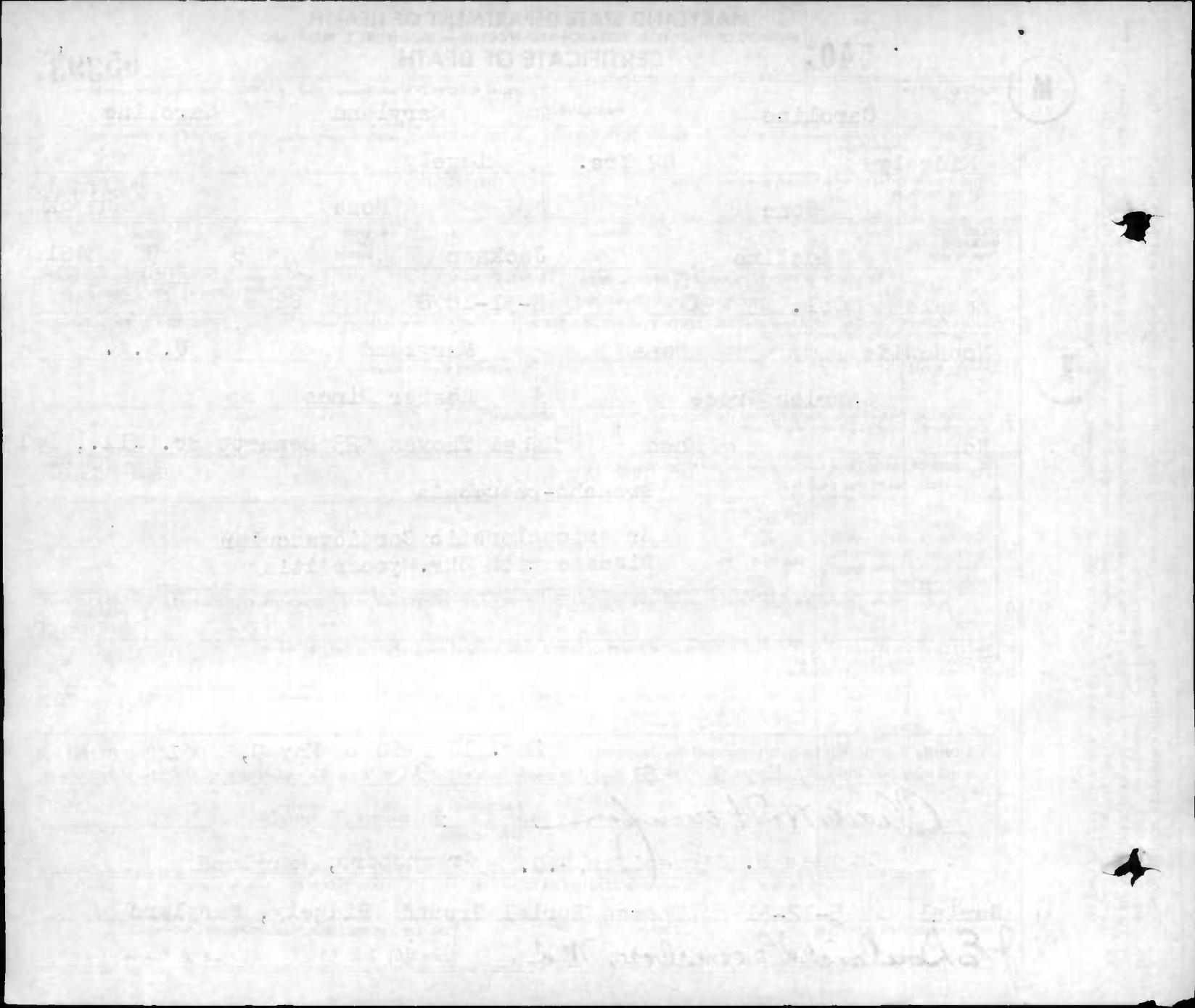
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5401

CERTIFICATE OF DEATH

65393

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 82 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Ridgely	
3. NAME OF DECEASED (Type or print) Adeline		4. DATE OF DEATH Jackson Month 5 Day 9 Year 1961	
S. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-31-1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Groce		14. MOTHER'S MAIDEN NAME Hester Hines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mabel Thomas		Address 823 Bennett St. Wil., Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia			
INTERVAL BETWEEN ONSET AND DEATH			
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO Arteriosclerotic Cardiovascular Disease with Chr. Myocarditis			
DUE TO Arteriosclerotic Cardiovascular Disease with Chr. Myocarditis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 10 1960 to May 9, 1961 , that (I) (we) last saw the deceased alive on May 9 1961 and that death occurred at 9A M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonerifer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonerifer, M.D.		22d. ADDRESS Greensboro, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-12-61	
23c. NAME OF CEMETERY OR CREMATORIAL Thomas Burial Ground		23d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulaire Greensboro, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE MAY 15 '61	
		25b. REGISTRAR'S SIGNATURE Charles J. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05394

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)				
Caroline MARYLAND		a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Rural Henderson	9 Yrs.	X Rural Henderson				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
None		None				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
Carl		Larsen				
4. DATE OF DEATH	Month	Day	Year			
	5	15	19 61			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-24-1893	67 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Farm Owner		None		Norway		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Martin Larsen		No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
		064-03-7386		Helene Bjerge		Henderson, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun Sh. Wound To Chest</i> DUE TO 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Internal Hemorrhage</i> DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>Gun Sh. Wound To Chest</i>				
20c. TIME OF INJURY Month, Day, Year Hour o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
5 5-15 19 61		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	Home	Henderson	Baltimore	Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Dawson O. George</i>		DATE SIGNED <i>May 16, 1961</i>				
EXAMINER'S NAME (Type) <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-17-61</i>		22c. NAME OF CEMETERY OR CREMATORIALY <i>Greensboro</i>		22d. LOCATION (City, town, or county) (State) <i>Greensboro, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaist</i>		ADDRESS <i>Greensboro, Md.</i>		24a. REC'D BY REGISTRAR <i>May 17 61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

65395

1. PLACE OF DEATH a. COUNTY		CAROLINE E MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL DENTON life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
WILLIAM EMMETT				LORI	May	8	1961	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost, birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
M	W		Apr 29, 1877	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	building	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM LORI	WILHELMINA RUSSEM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		Wm Paul Maloney, Denton, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		several months
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Generalized debility
DUE TO (c)		Inanition & Dehydration 5 days
DUE TO		Agony

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
Old Cerebral Thrombosis with left hemiparesis		

20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour a. m. p. m.	19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				

21. I certify that I attended the deceased from 28 April, 1961, to _____, 19_____, that I last saw the deceased alive on 28 April, 1961, and that death occurred at 1:15 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE	Dale R Kellman			M.D.	ADDRESS (Street, city or town, state)	DATE SIGNED

PHYSICIAN'S NAME (Type)	Dale R Kellman			M.D.	11 May 1961
-------------------------	----------------	--	--	------	-------------

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)
Burial	May 11, 1961	Denton	Denton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
J. King Jr.	before door Denton, Md.	DATE MAY 18 '61	Arthur S. Kraus

CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF MARRIED NAME	
JAMES R. HARRIS		HARRIS	
ADDRESS		ADDRESS	
1111 WOODSTOCK DR.		1111 WOODSTOCK DR.	
DETROIT, MI 48226		DETROIT, MI 48226	
AGE		AGE	
65		65	
SEX		SEX	
MALE		MALE	
MATERIAL TESTED		TESTING FOR	
BLOOD		BLOOD	
DEATH CERTIFICATION		DEATH CERTIFICATION	
DEATH OCCURRED ON		DEATH OCCURRED ON	
APRIL 10, 1981		APRIL 10, 1981	
TIME OF DEATH		TIME OF DEATH	
10:00 AM		10:00 AM	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MEDICAL RECORD NUMBER		MEDICAL RECORD NUMBER	
1234567890		1234567890	
NAME OF DOCTOR		NAME OF DOCTOR	
DR. JAMES R. HARRIS		DR. JAMES R. HARRIS	
ADDRESS OF DOCTOR		ADDRESS OF DOCTOR	
1111 WOODSTOCK DR.		1111 WOODSTOCK DR.	
DETROIT, MI 48226		DETROIT, MI 48226	
SIGNATURE		SIGNATURE	
JAMES R. HARRIS		JAMES R. HARRIS	
DATE		DATE	
APRIL 10, 1981		APRIL 10, 1981	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05396

5404		Item 9 File C287 5/22/61			
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)			
CAROLINE MARYLAND		a. STATE	MARYLAND		b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RUSKIN DENTON				X RURAL RIDGELY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
DAVID				MORGAN	MAY 7 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years, months, days) Feb. 15, 1904 77 yrs.
M		N		Feb. 15, 1904	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
COLLECTOR		JUNK		NORTH CAROLINA USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WYLIE MORGAN		CORELIA WILLIS		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				MRS. VALLIE CALDWELL, DENTON, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Severe</u> DUE TO <u>4/31X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH <u>few months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Lawson George</u>		DATE SIGNED <u>May 10, 1961</u>			
EXAMINER'S NAME (Type) <u>Lawson George, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAY 11, 1961		22c. NAME OF CEMETERY OR CREMATORIUM SPRINGROVE	
22d. LOCATION (City, town, or county) DENTON, MD		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. VIRGIL MOORE & SON		ADDRESS DENTON		24a. REC'D. BY REGISTRAR MAY 18 '61	
				24b. REGISTRAR'S SIGNATURE <u>Claire S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE BOARD OF HEALTH - DEPARTMENT OF
MEDICAL EXAMINERS CERTIFICATE OF DEATH

104-31

104-31

NAME
HARRISON

ADDRESS
1234 5TH AVENUE, GREEN BAY, WISCONSIN

PHONE NUMBER
444-1234

DEATH DATE
MARCH 12, 1968

AGE AT DEATH
65 years

CAUSE OF DEATH
COPD

DEATH CERTIFICATION
DEATH CERTIFIED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05397

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b 10 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NONE		e. STREET ADDRESS NONE	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN ERVIN NICHOLS		4. DATE OF DEATH Month MAY Day 6 Year 1961	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH APR. 14 1895		9. AGE (in years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME JOHN L. NICHOLS		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 214-12-5896	17. INFORMANT Leon Nichols Riddley, Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address Ridgely, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (b) 2nd Degree Burns over body DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hij Haze	
20c. TIME OF INJURY Month, Day, Year Hour 4 o. m. 4-16 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) His Home
20f. (City or town) Reed Burton		(County) Caroline	
		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dawson O. George		DATE SIGNED 5-6-61	
EXAMINER'S NAME (Type) Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAY 8, 1961	22c. NAME OF CEMETERY OR CREMATORIAL Greensboro
22d. LOCATION (City, town, or county) Greensboro		(State) N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Berlais		ADDRESS Greensboro, N.C.	24a. REC'D BY REGISTRAR Arthur S. Kraus DATE MAY 9 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1 FOR STATE
HEALTH DEPT.

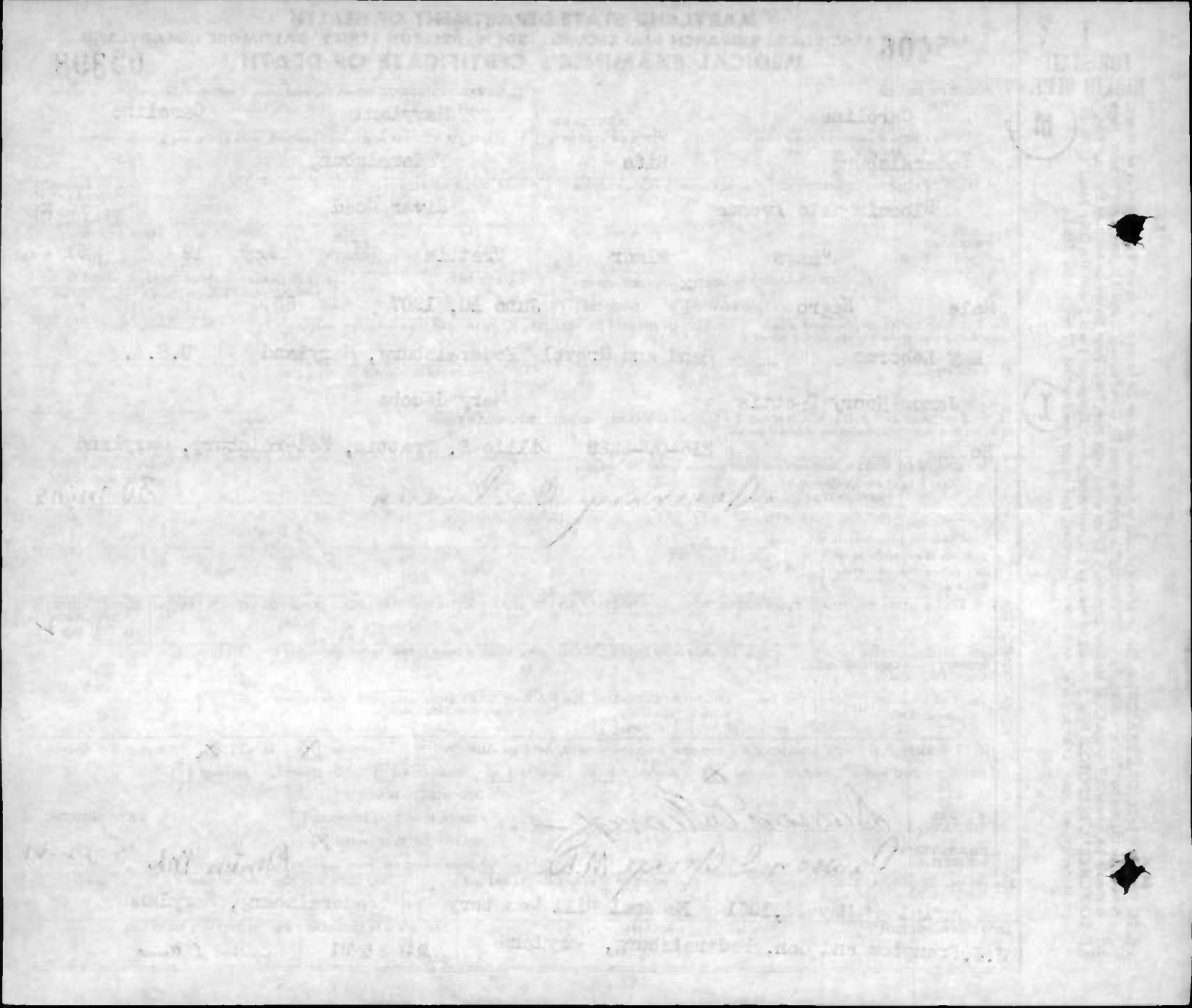
TO DIRECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65398

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN 1b Life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bloomingdale Avenue				e. STREET ADDRESS River Road	
3. NAME OF DECEASED (Type or print) James		First Elmer	Middle Prattis	4. DATE OF DEATH May 19	Month Day Year 1961
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1907	9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Sand and Gravel		11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland	
13. FATHER'S NAME James Henry Prattis		16. SOCIAL SECURITY NO. 216-09-3229		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		17. INFORMANT Lillie S. Prattis, Federalsburg, Maryland		Address	
No		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 50 mins	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Dawson D. George</i> DATE SIGNED <i>5-22-61</i> EXAMINER'S NAME (Type) <i>Dawson D. George M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22, 1961	22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery	22d. LOCATION (City, town, or country) Federalsburg, Maryland	
23. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR MAY 25 '61	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

65399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Caroline b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Denton	
3. NAME OF DECEASED (Type or print)		First Clarence Edward Scofield	Middle
4. DATE OF DEATH		Month May 13,	Day 19 Year 61
S. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 7, 1896
8. AGED (In years lost birthday) 64 yrs.		9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tenant		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Roxanna Scofield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Clarence Scofield, Denton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		15 minutes INTERVAL BETWEEN ONSET AND DEATH	
Coronary Occlusion		420.1	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		4 yrs	
(b)		Hypertension	
DUE TO		6 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Syphilis treated adequately 1952. Diabetes 4 years		029	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25, 1938 to May 13, 1961, that I last saw the deceased alive on April 28, 1961, and that death occurred at 1:15 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE E. Paul Knotts M.D.		406 Market St	
PHYSICIAN'S NAME (Type)		Denton, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1961	
22c. NAME OF CEMETERY OR CREMATORIAL Bell's Chapel		22d. LOCATION (City, town, or county) near Denton, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.W. Knotts, Denton, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knotts	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH DATE

TIME OF DEATH

AGE AT DEATH

SEX

RACE

CAUSE OF DEATH

MANNER OF DEATH

DEATH CERTIFICATION

DEATH REPORT

DEATH RECORD

DEATH INDEX

DEATH CARD

DEATH FILE

DEATH NUMBER

DEATH CODE

DEATH DATE

DEATH TIME

DEATH AGE

DEATH SEX

DEATH RACE

DEATH CAUSE

DEATH MANNER

DEATH CERT

DEATH REP

DEATH REC

DEATH IND

DEATH CAR

DEATH FILE

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DEATH IND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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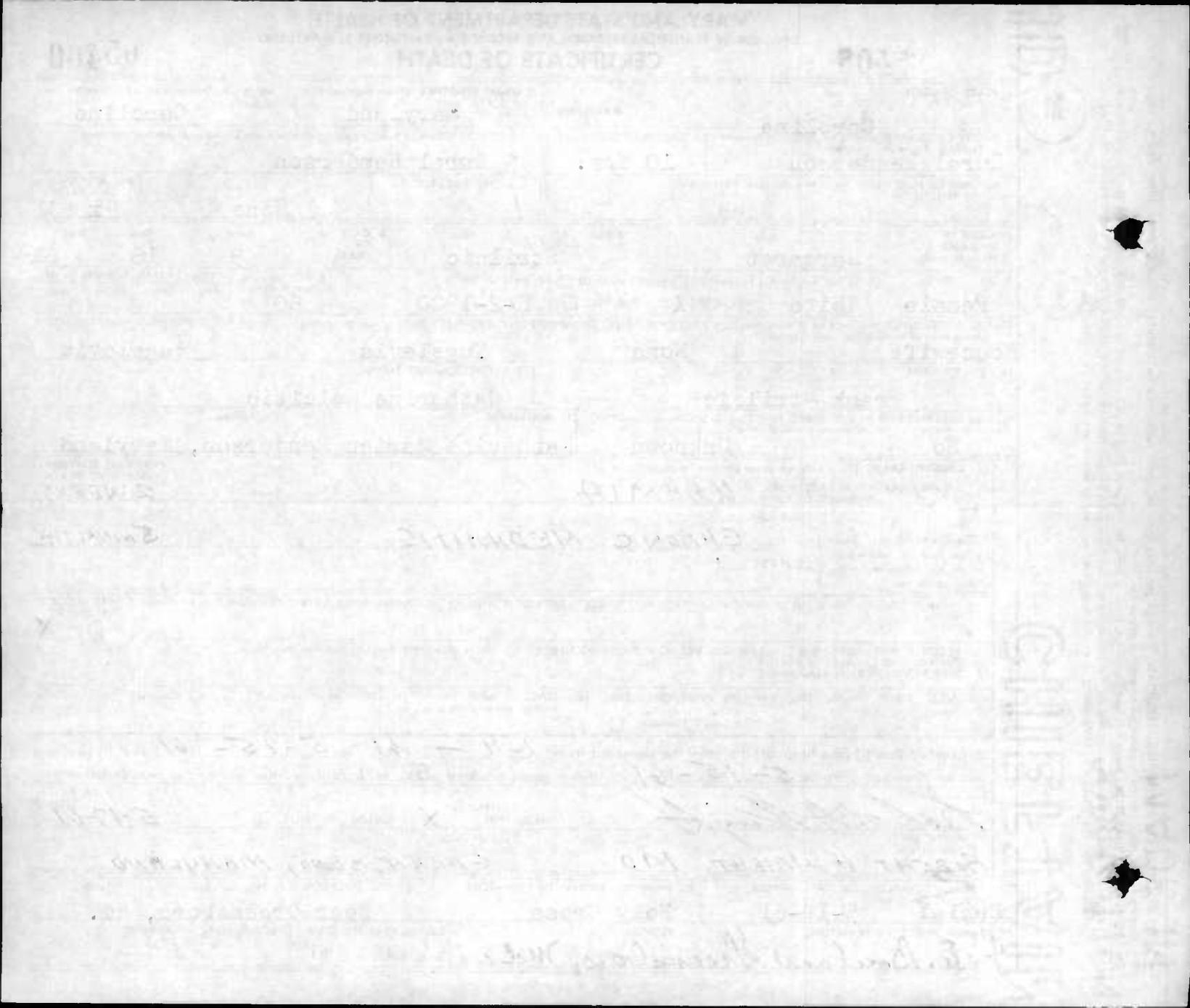
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5408

65400

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN lb 10 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. STREET ADDRESS X Rural Henderson	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret		First	Middle
		Last	Strilcic
4. DATE OF DEATH 5 16 19 61		Month	Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-2-1900		9. AGE (In years lost birthday) 60 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? Yugoslavia ✓	
13. FATHER'S NAME Frank Strilcic		14. MOTHER'S MAIDEN NAME Catherine Melcitic	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Katherine Marien Henderson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC NEPHRITIS</u>		5 MONTHS	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(b)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-11 - 1961, to 5-15-1961, that (I) (we) last saw the deceased alive on 5-15-1961, and that death occurred at 6P M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert H. Knight</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Robert H. Knight MD		22d. ADDRESS GREENSBORO, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-19-61	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City, town, or county) (State) Near Greensboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaais Greensboro, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE MAY 19 '61	
		25b. REGISTRAR'S SIGNATURE Cirinder S. Turner	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 5401

M		5409									
X		1. PLACE OF DEATH a. COUNTY		CAROLINE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MARYLAND	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		DENTON		c. LENGTH OF STAY IN 1b		DENTON		b. COUNTY	
I		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX		M	DANIEL	N	TAPLEY	May	30	1961			
6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday) 63 yrs.		10. UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Day LABORER		CANNING		VIRGINIA		USA					
13. FATHER'S NAME		unknown		14. MOTHER'S MAIDEN NAME		unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		577-12-3384		WILSON COHEE		DENTON MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		Myocardial Failure, Severe		INTERVAL BETWEEN ONSET AND DEATH					
4222		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Myocarditis, Chronic		immediate					
DUE TO (b)		DUE TO (c)				Several months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE		Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED					
EXAMINER'S NAME (Type)		Dawson O. George MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)						
Burial		June 4/61	Lynx Durg Va	Lynchburg	VA						
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE JUN 6 '61		24b. REGISTRAR'S SIGNATURE						
L. V. DRAPER MORTGAGE CO. INC.		Denton			Arthur S. Thane						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF PUBLIC SAFETY
MICHIGAN DEPARTMENT OF PUBLIC SAFETY
DEPARTMENT OF PUBLIC SAFETY
DEPARTMENT OF PUBLIC SAFETY

M

MARTHA

WHITE ROSE FLOWERS

WHITE ROSE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5410

CERTIFICATE OF DEATH

Reg. Dist. No. 65402

1. PLACE OF DEATH o. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON c. LENGTH OF STAY IN 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIOLET First ANN Middle TAYLOR Last		4. DATE OF DEATH Month May Day 7 Year 1961	
5. SEX F 6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Feb 1, 1877	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME NELSON BLIZZARD		14. MOTHER'S MAIDEN NAME LUCINDA CAPLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Dolly Moore, Denton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. 420.1 (b) General atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1956 to May 7, 1961, that I last saw the deceased alive on May 7, 1961, and that death occurred at 11 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE E. Paul Knotts M.D.		ADDRESS (Street, city or town, state) 406 Market St DATE SIGNED	
PHYSICIAN'S NAME (Type) E. Paul Knotts M.D.		22c. NAME OF CEMETERY OR CREMATORIAL BETHEL CHURCH	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1961	
22d. LOCATION (City, town, or county) Carrollton (State) Md		22c. REC'D BY REGISTRAR DATE MAY 10 '61	
23. FUNERAL DIRECTOR'S SIGNATURE		24b. REGISTRAR'S SIGNATURE	
Dr. George Moore & Son Denton		Arthur S. French	

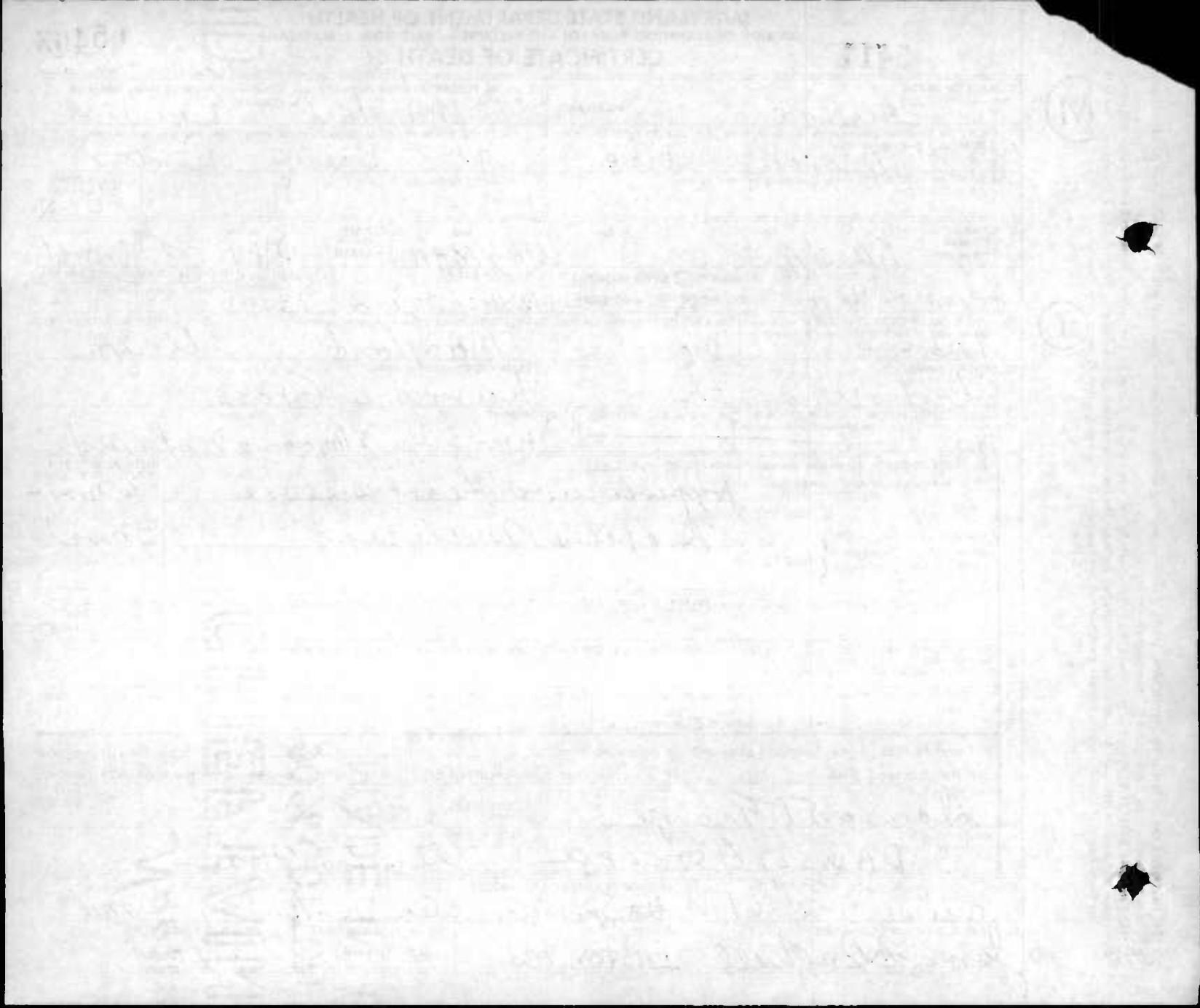
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH Item 4 Film Y-288. 6/2/61 exec. 05403											
1. PLACE OF DEATH a. COUNTY <u>Caroline</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 21.3 Box 77 - Denton</u>		d. STREET ADDRESS <u>1</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First <u>Rhoda</u> Middle <u></u> Last <u>WAYMAN</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1961</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 27 1888</u>		9. AGE (In years last birthday) <u>73</u> yrs. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Charles W. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Hurenia Gross</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT <u>James L. Wayman - Denton, Md.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperlentis Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> 3mos DUE TO (c) <u></u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u>Denton</u> (County) <u>Caroline</u> (State) <u>Maryland</u>			
21. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) lost the deceased alive on _____ 19_____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Dawson O. George</u>				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u></u>			
22c. PHYSICIAN'S NAME (Type) <u>Dawson O. George</u>				22d. ADDRESS <u>Denton Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-61</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>De Spring Grove Cen.</u>		23d. LOCATION (City, town, or county) <u>Denton</u> (State) <u>Caroline</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Dashill</u> ADDRESS <u>EASTON, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>May 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

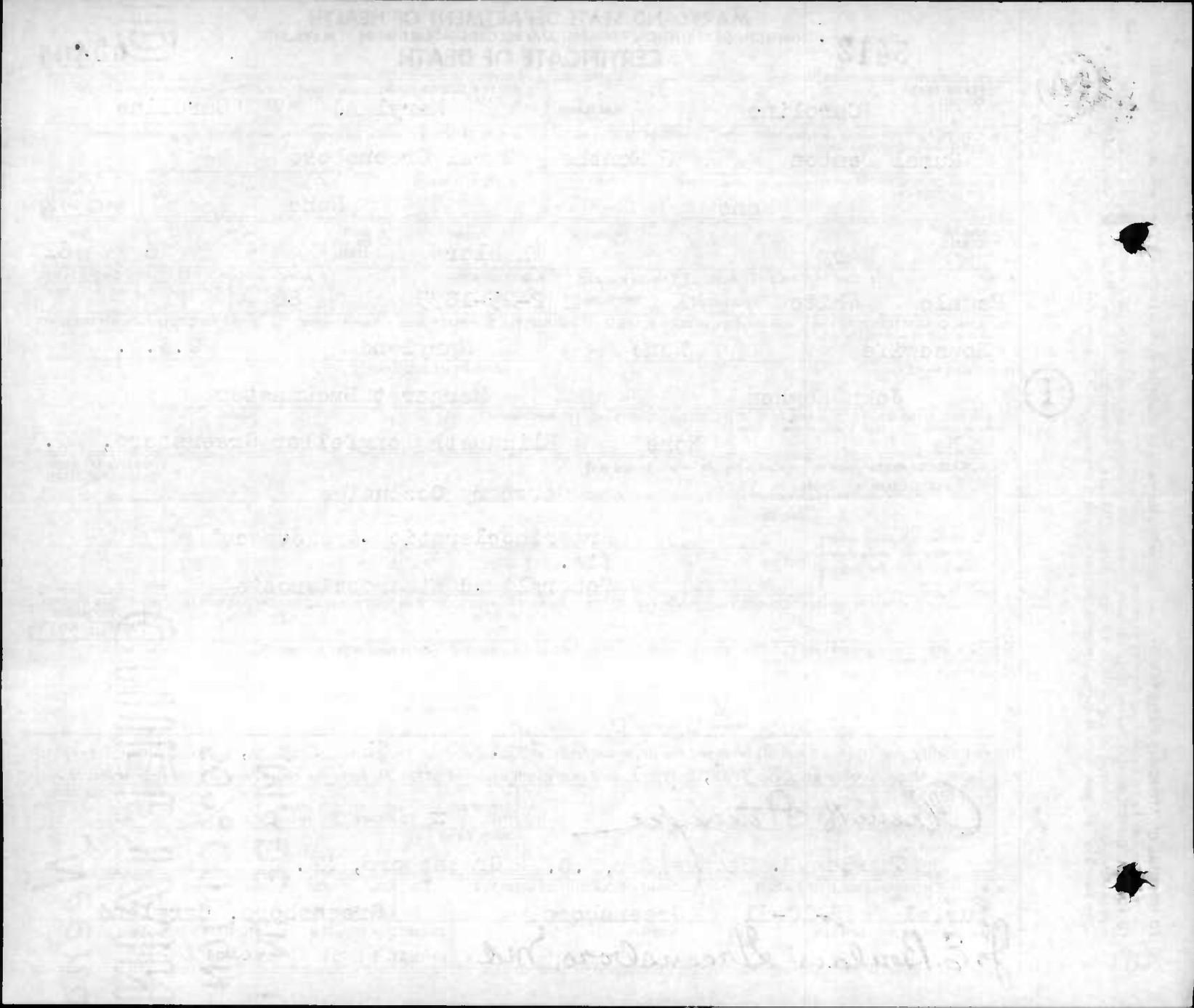
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5412 65404

1. PLACE OF DEATH a. COUNTY Caroline		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton		c. LENGTH OF STAY IN 1b 6 Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro X		d. STREET ADDRESS None				
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Lost	Wheeler	4. DATE OF DEATH 5	Month	Day	Year 6 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-1875		9. AGE (In years lost birthday) yrs. 86		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Margaret Buckmaster				Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elizabeth Longfellow		Greensboro, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerotic Cardiovascular Dis.		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO cause (a), stating the underlying cause last. (b)		Generalized Atherosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 10 1961 to May 6, 1961 that (I) (we) last saw the deceased alive on May 6, 1961, and that death occurred at 4A M, from the causes and on the date stated above.										
22a. SIGNATURE Charles H. Stonestaf				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Charles H. Stonestaf, M.D.		22d. ADDRESS Greensboro, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-61		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro		23d. LOCATION (City, town, or county) Greensboro, Maryland		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR DATE MAY 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

5413 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05495

1. PLACE OF DEATH o. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 70 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Beniah		First Beniah	Middle Lewis
		Last Wothers	4. DATE OF DEATH May 4 1961
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Wothers		14. MOTHER'S MAIDEN NAME Sarah ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-22-7274	17. INFORMANT Charles Wothers
		Address Greensboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
INTERVAL BETWEEN ONSET AND DEATH			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 24 1961 to May 4, 1961 , that (I) (we) last saw the deceased alive on May 4, 1961 and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Chas. H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-7-61	23c. NAME OF CEMETERY OR CREMATORIAL Bursville	23d. LOCATION (City, town, or county) (State) Bursville, Del.
24. FUNERAL DIRECTOR'S SIGNATURE John E. Boulaia		ADDRESS Greensboro, Md.	25a. REC'D BY REGISTRAR DATE MAY 9 '61
			25b. REGISTRAR'S SIGNATURE Arthur L. Krause

